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H. Disproportionate Share

1. Minimum Eligibility Criteria

Indigent volume data is taken from each hospital's cost report and from supplemental forms that each hospital must file with its cost report. Separate indigent volume data is collected for and applied to distinct part psychiatric units.

Indigent volume is measured as the percentage of inpatient indigent charges to a hospital's total inpatient charges. Indigent charges are the annual charges for services rendered to patients eligible for payments under the Medicaid, Patient Care Management System Programs plus uninsured care charges. Uninsured care is limited by Medicare standards and is offset by any recoveries.

Each hospital must have an inpatient Medicaid utilization rate of at least 1%. Inpatient Medicaid utilization is measured as:

$$\frac{\text{Medicaid Inpatient Days (Whole Hospital, including Subproviders)}}{\text{Total Hospital Days (Whole Hospital, including Subproviders)}}$$

Days will be taken from hospital filed cost reports for fiscal years ending between October 1, 1993, and September 30, 1994.

Effective October 1, 1993, individual inpatient hospital claims will be paid without DSH adjustments. For state FY96, inpatient DSH payments will be made in a single distribution based on charges converted to cost using a cost to charge ratio. The payment will be made sometime during the first quarter of the state fiscal year. Each hospital's indigent volume is taken from hospital cost reporting periods ending between October 1, 1993 and September 30, 1994.

The Title XIX charges used to compute DSH payments will be the sum of Title XIX charges and Title XIX HMO charges from hospital indigent volume reports for cost periods ending between October 1, 1993 and September 30, 1994. Data for cost periods of more or less than one year will be proportionally adjusted to one year.

Hospital operating cost ratios will be taken from hospital cost reporting periods ending between October 1, 1993 and September 30, 1994. For hospitals with more than one cost reporting period ending in this date range will have their data from the two periods added and a single ratio will be computed. If the ratio is greater than 1.00, a ratio of 1.00 will be used.

Reimbursement for inpatient hospital services under Title V will not include DSH payments.

Hospitals that fail to supply indigent volume data will not be eligible to receive disproportionate share payments.

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For new hospitals, DSH payments will be withheld until the hospital's indigent volume can be calculated and applied in the normal update process.

For new distinct part psychiatric units of general hospitals, the indigent volume data from the general hospital will be used to determine DSH payments applicable to the distinct part psychiatric units until the unit's indigent volume can be calculated and applied in the normal update process.

To be eligible to receive DSH payments, hospitals must also meet at least one of the following criteria. Except for hospitals and distinct part psychiatric units eligible under criteria #4, hospitals will be contacted annually by letter and asked to report their status on these criteria.

The hospital must:

a. have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals who are eligible for Medicaid services; or

b. be located in a rural area (as defined for purposes of section 1886 of the Social Security Act) and have at least two (2) physicians with staff privileges at the hospital who have agreed to provide obstetric services to individuals who are eligible for Medicaid services; or

c. serve as inpatients a population predominantly comprised of individuals under 18 years of age; or

d. as of December 22, 1987, not have offered non-emergency obstetric services to the general population.

2. Calculation of DSH Ceiling

All charge, cost and payment data must be on an accrual basis for each hospital's cost reporting period ending between October 1, 1993 and September 30, 1994. Data should be separated by subprovider.

The ceiling calculation is:

Base Year Title XIX Charges _____.
X Title XIX Cost to Charge Ratio _____.
Title XIX Costs _____.
X Inflation _____.
FY 1996 Title XIX Costs _____.

Base Year Uninsured Charges _____.
X Cost to Charge Ratio _____.
Uninsured Costs _____.

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X Inflation _____.
FY 1996 Uninsured Costs_____.
Base Year Title XIX Payments_____.
- Base Year DSH _____.
- Base Year Special Outpatient Adjustors _____.
- Base Year Outpatient Adjustors _____.
Adjusted Base Year Payments _____.
X Inflation _____.
Inflated Payments _____.
+ FY 1996 Special Outpatient Adjustors _____.
+ FY 1996 Outpatient Adjustor Payment _____.
+ FY 1996 Payments for Uninsured _____.
FY 1996 Payments _____.

The ceiling is then:

FY 1996 Title XIX Costs _____.
+ FY 1996 Uninsured Costs _____.
- FY 1996 Payments _____.
Ceiling _____.

a. Base Year Data

1) Title XIX Charges:

Base year Title XIX charges including Title XIX charges for those enrolled in HMO's and Medicaid clinic plans and patients dually enrolled in Title V and Title XIX.

2) Title XIX Costs:
The total Base Year Title XIX Charges times the hospital's Title XIX cost to charge ratio for the cost reporting period. The cost to charge ratio should be inclusive of capital and medical education costs.

3) Uninsured Charges:
Charges for services provided to patients who did not have any insurance coverage, or for services not covered by the patient's insurance coverage. Services covered by Medicare and/or Medicaid may not be included as uninsured charges.

4) Uninsured Costs:
The total Base Year Uninsured Charges times the hospitals cost to charge ratio. The cost to charge ratio should be inclusive of capital

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and medical education costs. Hospitals may designate the appropriate ratio for this calculation as either the Title XIX cost to charge ratio or the overall hospital cost to charge ratio.

5) Title XIX Payments

Payments for the services included in computing the Base Year Title XIX Charges. Payments must include capital and medical education payments, but must exclude Base Year Title XIX DSH payments, Special Title XIX Adjustor payments, and regular outpatient adjustor amounts.

6) Uninsured Payments

Payments by or on behalf of an individual patient for the services included in computing the Base Year Uninsured Charges.

b. Adjustments to Base Year Data

1) DSH Payments

Prior to October 1, 1993, the Medicaid Title XIX DRG and Per Diem Rates included a factor for DSH payments. After that date, DSH payments were made in a single lump sum for the State fiscal year.

- Prior to October 1, 1993

Hospitals with cost reporting periods including service admissions prior to October 1, 1993 must allocate a portion of their payments to this period. Hospitals may elect to proportionally allocate payments (e.g., a hospital with FYE 12/31/93 may assign 75% of payment to the period before 10/1/93), or hospitals may elect to use actual data from its records to allocate payments.

Using the appropriate factor from their price sheets, hospitals must divide their Base Year Title XIX operating payments from the period before October 1, 1993 by the DSH factor for their hospital. The DSH factor represents the amount of increase in the hospital's DRG price and/or Per Diem for DSH payments. Subtracting this amount from the Base Year Title XIX Payment determines the Base Year DSH Payment that was included in the rate.

Since DSH payments were included in the amount paid to HMOs, the DSH adjustment should be applied to Title XIX HMO payments as well.

- State FY 1994
(October 1, 1993 - September 30, 1994)

Hospitals received a lump sum DSH payment(s) during State FY 1994.

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Hospitals whose cost reporting period began before October 1, 1993 will determine the proportion of FY 1994 DSH to be deemed Base Year DSH Payment by using the balance of their Base Year Title XIX Payments (after subtracting the amount allocated to the period before October 1, 1993) divided by the hospital's total Base Year Title XIX Payments. This proportion times the FY 1994 DSH payments will determine the DSH payment for the hospital for the period after October 1, 1993.

Hospitals whose cost reporting period began on October 1, 1993 should use the DSH amount from FY 1994 as the Base Year DSH Payment.

2) Special Adjustors

Payments made from special Title XIX pools must be subtracted from the Base Year Title XIX Payments. These include the special DSH payments made to publicly owned hospitals, the special outpatient pool payments, and special outpatient adjustors paid to publicly owned hospitals.

Anticipated FY 1996 Special Adjustor payments must be added to the base year data.

3) Outpatient Adjustors

Outpatient payments include an adjustor for indigent care and indirect education that is changed each year. To account for that change, the Base Year payments are adjusted to remove the adjustor from the base year. The adjustor, for each hospital must be removed from the Title XIX outpatient payments after special adjustors have been subtracted from the hospital's Base Year Title XIX outpatient payment amounts.

The Title XIX outpatient adjustor to be used in FY 1996 must be applied to the expected FY 1996 Outpatient payment amounts.

4) Inflation

Inflation of Base Year costs (inpatient and outpatient) is computed using the DRI index of inflation for the whole hospital. Hospitals are inflated to a common FYE of 9/30/94 and then to State FY 1996 (ending 9/30/96).

Inflation of payments is computed from the hospital's rate change over time. Outpatient payments are not inflated since there have been no rate increases since 1991.

c. Selection of Ceiling Option

For purposes of the DSH ceiling, hospitals may elect to use only inpatient data, or may combine inpatient and outpatient data. Unless hospitals specify otherwise, the MSA will assume that each hospital elects the option allowing the largest possible DSH payment.

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3. Regular Disproportionate Share Hospital (DSH) Payments FY 1996:

State fiscal year 1996 disproportionate share hospital payments for services in all hospitals are fixed at $45 million. The pool allocations were determined as follows:

$$\frac{\sum \text{ DSH Shares for Group}}{\text{Total DSH Shares}} X \$45 \text{ Million}$$

The determination of the share of the allocated DSH pool will be made using the DSH share. The payment will be made by:

$$\frac{\text{Hospital's DSH Share}}{\sum \text{ Total DSH Shares}} X \text{ Allocated DSH Pool}$$

The payment amount each hospital is to receive will be determined by comparing the individual hospital payment obtained using the above formula to the individual hospital payment ceiling. Any amounts not paid to a hospital because of the OBRA 1993 limits will be returned to the pool and redistributed using the same formula as the initial distribution with hospitals over the ceiling removed from the calculation. This process will continue until the entire pool is distributed. DSH amounts that cannot be paid because of the ceiling will be withheld from a hospital in the following order:

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- Distinct Part Rehab Unit DSH Payment

  Any hospital that is above the DSH ceiling that is eligible for payment from the distinct part rehab unit DSH pool will forfeit DSH payments from the distinct part rehab unit pool in an amount necessary to get to the limit.

- DRG Reimbursed Hospital

  If a hospital is not eligible for a distinct part rehab unit DSH payment, or if forfeiting the hospital's distinct part rehab unit DSH payment is not sufficient to put the hospital below the DSH ceiling, the hospital will forfeit DSH payments from the DRG hospital pool in an amount necessary to get to the limit.

- Per Diem Reimbursed Hospitals and Units

  If the above two steps are not sufficient to get the hospital below its DSH ceiling, the hospital will forfeit DSH payments from the Per Diem Reimbursed hospital and unit pool in an amount necessary to get to the DSH limit.

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The individual pool amounts are listed below.

a. DRG Reimbursed Hospitals

10/01/95 The DSH payments for DRG reimbursed hospitals are split into two pools. The indigent volume is shown on hospital price sheets for rates effective October 1, 1995.

- Hospitals with at Least 50% IV

  The share of the DSH payment paid to hospitals with at least 50% indigent volume (IV) is approximately $7.3 million and is based on a DSH computed as:

  Title XIX Charges X Operating Ratio X (IV - 0.5)

- Hospitals with at Least 20% IV

  The share of the DSH payment paid to hospitals with at least 20% IV is approximately $30.2 and is based on the following DSH amount. This is in addition to the amount above:

  Title XIX Charges X Operating Ratio X (IV - 0.2)

b. Per Diem Reimbursed Hospitals
(Including TEFRA Option Rehab Hospitals)

Per diem reimbursed hospitals are allocated approximately $7 million for DSH payments. The per diem factor is set prospectively using current indigent volume survey data. The share of the DSH paid to hospitals with IV of at least 20% is based on a DSH share of :

Title XIX Charges X Operating Ratio X (IV - 0.2)

c. Distinct Part Rehab Units

Distinct Part Rehabilitation units are allocated approximately $½ million for DSH payments. The share of the DSH payment paid to hospitals with IV of at least 20% is based on a DSH share of:

Title XIX Charges X Operating Ratio X (IV - 0.2)

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4. **Special Disproportionate Share Hospital (DSH) Payments FY 1996 for Public Hospitals**

Determination of the special public hospital DSH payment is based on 100% of Medicaid and uinsured cost.

Each public hospital's maximum payment is calculated as follows:

[(Title XIX Cost + Uninsured Care Cost) - (Title XIX payments + Uninsured Care Payments)] - Regular DSH Payment

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The maximum payment amount may be reduced if funds are not available to finance the payment.

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I. Capital

The initial reimbursement for capital will be paid as a separate Capital Interim Payment (CIP). CIPs will be made using a semimonthly schedule (24 payments per year). The CIP amount will be set using the most recent available cost data and an estimated impact of any applicable limits on capital. CIP amounts will be set annually at the beginning of the hospital's fiscal year. CIPs may be adjusted due to significant changes in capital costs that are not reflected in the most recent cost report.

After the end of the facility's fiscal year, the total amount paid under CIP is compared with total capital cost as reported on the filed cost report for that year less any capital limits that apply. Differences are gross adjusted.

If a hospital has a separate distinct part psychiatric unit, separate CIPs, comparisons to actual costs and determination of appropriate limits will be made for the distinct part unit and the balance of the inpatient hospital.

The Medicaid share of allowable capital costs is determined using Medicare Principles of Reimbursement.

The limits on capital described in this section apply for fiscal years beginning on and after October 1, 1990. The net licensed beds days calculation for hospitals whose fiscal year begins after September 30, 1990 and before January 1, 1991 and that reduce their licensed bed capacity by delicensing beds or using the rural banked beds option before January 1, 1991 will be made as if the reduction occurred on October 1, 1990.

HCFA-179 S 90-33 Date Rec'd 12/21/90
Supercedes Date Appr. 12/16/91
... Rep. In DJB Date Eff. 10/1/90

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Net licensed beds are used to determine net licensed bed days for capital reimbursement and include all beds temporarily delicensed, except for rural banked beds, with rural as defined under section I-2. Net licensed bed days are:

Total Licensed Bed Days - Rural Banked Bed Days

A hospital may apply for a reduction in net licensed beds days to subtract bed days unavailable due to construction or renovation. Such a reduction is only available for beds which are taken out of service for construction or renovation for a limited period of time and which are returned to active inpatient service at the end of the construction or renovation project. Documentation of the construction or renovation project will be required.

Occupancy is:

$$\frac{\textit{Total Inpatient Days (Including Nursery Days)}}{\textit{Net Licensed Bed Days}}$$

1. Sole Community Provider Eligible Hospitals

If the hospital is eligible for sole community provider status (as defined by Medicare standards), the Medicaid share of allowable capital costs is reimbursed in full.

The Medicaid share of allowable capital costs of any distinct part psychiatric units in sole community provider eligible hospitals is reimbursed in full.